

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

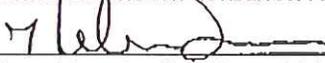
PRINTED: 12/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185227	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  12/05/2013
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NAME OF PROVIDER OR SUPPLIER  SUPERIOR CARE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 3100 CLAY STREET PADUCAH, KY 42001
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000  F 241 SS=D	<p><b>INITIAL COMMENTS</b></p> <p>A Recertification Survey was conducted on 12/03/13 through 12/05/13 to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with the highest S/S of "F".</p> <p><b>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</b></p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review and facility policy review it was determined the facility failed to promote care for residents in a manner and in an environment that maintains or enhances each residents' dignity for two (2) of fifteen (15) sampled residents (Resident #9 and Resident #7). The facility failed to provide a dignity bag for Resident #9's catheter bag which contained yellow fluid which could be seen from the hall outside of the resident's room.</p> <p>The findings include:</p> <p>Review of the facility policy titled, "Resident Rights", (no dated), revealed the facility will make every effort to assist each resident in exercising his/her rights to assure that the resident is always treated with respect, kindness, and dignity.</p> <p>Record review revealed the facility admitted</p>	F 000  F 241	<p><b>Preparation and execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. This Plan of Correction is prepared and executed solely because it is required by federal and state laws. The facility reserves the right to revise/improve corrective actions as determined to be warranted.</b></p> <p><b>F241</b></p> <ol style="list-style-type: none"> <li>1) Resident who have foley catheters have had them placed in dignity bags.</li> <li>2) Any resident with a foley catheter have the potential to be affected by the deficient practice.</li> <li>3) All residents utilizing foley catheters will have them placed in dignity bags to ensure the resident is treated with respect, kindness and dignity.</li> <li>4) Staff were inserviced on 12/18/13 regarding the use of dignity bags. The staff development nurse will observe from the hallway for the proper placement of foley catheters in dignity bags. This will be monitored twice a week for thirty days to ensure compliance.</li> </ol> <p>5) Completion date: 12/30/13</p>	12/30/13
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  	TITLE  Administrator	(X6) DATE  2-4-14
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 241	<p>Continued From page 1</p> <p>Resident #9 on 01/05/12 with diagnoses which included Alzheimer's and Urinary Retention. Review of the quarterly Minimum Data Set (MDS) assessment, dated 08/27/13, revealed the facility assessed Resident #9's cognition as severely impaired.</p> <p>Observation, on 12/03/13 at 10:55 PM, 3:47 PM, and 4:00 PM and on 12/04/13 at 11:00 AM, 12:30 PM, and 12/05/13 at 8:45 AM, revealed the resident was laying in bed with a urinary catheter bag to bedside. The catheter bag contained yellow fluid, was not covered and was visible to staff, other residents, and visitors from the hallway outside of the resident's room.</p> <p>Interview, on 12/03/13 at 10:52 AM with Certified Nursing Assistant (CNA) #1, revealed Resident #9's catheter bag contained yellow fluid and could be seen from the doorway. The CNA stated the facility has dignity bags to cover the catheter bags.</p> <p>Interview, on 12/03/13 at 11:30 AM with Registered Nurse (RN) #1, revealed Resident #9's catheter bag contained yellow fluid and could be seen from the hallway. The RN stated a dignity bag was needed.</p> <p>Interview, on 12/05/13 at 9:30 AM with RN #2, revealed Resident #9's catheter bag with yellow fluid in it needed a dignity bag because it could be seen from the doorway and that was a dignity issue.</p> <p>2. Record review revealed the facility admitted Resident #7 on 05/06/13 with diagnoses which included Fracture of Humerus, Head Injury, Urinary Retention, and Alzheimer's.</p>	F 241			

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F 241	Continued From page 2  Review of the quarterly MDS assessment, dated 10/23/13 revealed the facility had assessed Resident #7's cognition as severely impaired, and required extensive assistance from staff for all activities of daily living  Observation on 12/03/2013 at 10:15 AM and 3:43 PM, revealed Resident #7 was resting in bed with a urinary drainage bag hanging to bedside with yellow fluid in the bag visible from doorway.  Interview, on 12/05/13 at 10:20 AM with Director of Nursing (DON) and Administrator, revealed they did not feel that seeing the catheter from doorway was a concern.	F 241	<u>F253</u> 1) The vents in the bathrooms in 213 and 214 were cleaned by the housekeeping supervisor on 12/5/13.  2) All residents have the potential to be affected by the deficient practice.  3) Daily housekeeping cleaning schedules have been updated to include daily observation of the bathroom vents for cleaning as necessary.  4) The housekeeping supervisor will monitor the cleaning of the vents by observation of ten bathrooms a week for 30 days. Further follow up will be determined through the QA process by the findings during the observation period.		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES  The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.  This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility policy review it was determined the facility failed to ensure housekeeping services were provided to maintain a sanitary interior related to two dirty bathroom vents.  The findings include:  Review of the facility's housekeeping check off list titled, "Daily Deep Clean Check Off List", (no date), revealed staff should deep clean ceilings, vents, light fixtures, lights in the hallway and clean	F 253	5) Completion date: 12/30/13	12/30/13	

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F 253	Continued From page 3 bugs out of lights. Clean and disinfect toilet, wipe down entire outside area.  Observation on 12/03/13 at 10:18 AM and 2:30 PM and on 12/05/13 at 8:20 AM, revealed a vent in room #213 and #214 with copious amounts of gray fluffy particles.  Interview, on 12/05/13 at 8:40 AM with the Housekeeping Supervisor, revealed resident rooms should be deep cleaned monthly and vents did not look like they were cleaned.  Interview, on 12/05/13 at 10:20 AM with Administrator, revealed the closed off vents should not have anything on them and housekeeping pulls rooms once a month for deep cleaning.	F 253	<u>F371</u> 1) The meat slicer was cleaned upon discovery of the yellow substance, the frozen vegetables were disposed of and other items in the freezer were checked for proper date and closure. The staff person responsible for improper temperature probe sanitation during meal service was reinserviced as to the proper procedure.  2) All residents have the potential to be affected by the deficient practice.  3) Dietary staff have been reinserviced on the following: 1) Proper procedure for storage of opened food items i.e. dating items and properly sealing opened items. 2) The meat slicer is to be cleaned after every use. 3) The proper procedure for the sanitation of the temperature-probe with an alcohol pad.	
F 371 SS=F	483.35(l) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy/procedure, it was determined the facility failed to store and serve food under sanitary conditions.	F 371	4) The Dietitian will monitor weekly for the adherence to the policies and procedures regarding equipment cleanliness, temperature probe sanitation and food storage. Further follow up will be determined thru the QA process by the findings during the observation period.  5) Completion date: 12/30/13	12/30/13

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F 371	<p>Continued From page 4</p> <p>Review of the facility's Census and Condition, dated 12/04/13, revealed there were seventy-one (71) residents in the facility with no residents requiring tube feeding.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Review of the Equipment Cleaning Schedules policy/procedure, undated, revealed to clean the slicer daily, after each use.</li> </ol> <p>Review of the Frozen Storage policy/procedure, undated, revealed all frozen food would be properly wrapped, dated, and labeled.</p> <p>The following observations were made, on 12/03/13 at 10:30 AM, during the initial kitchen tour:</p> <ol style="list-style-type: none"> <li>1. A dried yellow substance was noted on the blade and surrounding area of the meat slicer.</li> <li>2. (1) package of frozen vegetables was unsealed and undated. There was ice buildup noted in the package.</li> </ol> <ol style="list-style-type: none"> <li>2. Review of the Tray Line and Meal Service Temperatures policy/procedure, undated, revealed the thermometer would be sanitized between taking each food's temperature. The following two procedures were acceptable:             <ol style="list-style-type: none"> <li>a) Wash in a pot sink with soapy water, rinse, dip in sanitizing solution</li> <li>b) Cleanse with alcohol swabs</li> </ol> </li> </ol> <p>The cook obtained food temperatures without properly cleaning the thermometer probe between items. The following observations were made, on 12/03/13 at 12:00 PM:</p>	F 371		
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F 371	Continued From page 5  1. Turkey- the probe was cleaned with a gloved finger 2. Barbecue- the probe was cleaned with a towel 3. Carrots- the probe was not cleaned 4. Baked beans- the probe was cleaned with a towel 5. Vegetables- the probe was not cleaned 6. Potatoes- the probe was cleaned with a towel 7. Navy bean soup- cleaned probe with a towel 8. Cream of chicken soup- cleaned probe with a towel 9. Pimento cheese- cleaned probe with a towel 10. Bologna- the probe was not cleaned 11. Cheese- the probe was not cleaned 12. Tomatoes- the probe was not cleaned  Interview with the Dietary Manager, on 12/03/13 at 10:45 AM and 12/04/13 at 4:00 PM, revealed she expected staff to clean the meat slicer in the dishwasher after each use, and clean the blade and surrounding area by hand with soapy water. She expected staff to ensure opened items in the freezer were sealed and dated. She verified staff should obtain food temperatures by cleaning the probe with a new alcohol swab after each food.  Interview with the Administrator, on 12/05/13 at 10:00 AM, revealed dietary staff were expected to follow the above policies.	F 371	<u>F441</u> <u>Handwashing/sanitizing during tray delivery</u> 1) Nurse aides were inserviced on 12/18/13 regarding handwashing/sanitizing during the meal time tray delivery.  2) All residents have the potential by the deficient practice.  3) The staff development nurse will be observing meal tray delivery to ensure the staff are properly washing/sanitizing their hands in between the delivery of a "clean" tray and the pick-up a "dirty" tray.  4) To ensure the staff is properly washing/sanitizing their hands, the meal tray delivery will be observed through the QA process. A minimum of one meal per week will be observed by the staff development nurse for one month, then once every other week for an additional month. Meals to be observed will be determined by the staff development nurse but each meal (breakfast, lunch and dinner) will be observed at minimum twice during the observation period. The number of staff observed will be determined by the staff on duty at the time observation. Further follow up will be determined through the QA process by the findings during the observation period.	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.	F 441	5) Completion date: 12/30/13	12/30/13

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NAME OF PROVIDER OR SUPPLIER  <b>SUPERIOR CARE HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3100 CLAY STREET PADUCAH, KY 42001</b>
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F 441	<p>Continued From page 6</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy/procedure, it was determined the facility failed to ensure staff washed their hands between each direct resident contact during meal service and failed to wash</p>	F 441	<p><u>Handwashing/Sanitizing during Peri/Catheter Care</u> 1) CNA #4 was re-educated by the staff development nurse on 12/5/13 regarding proper handwashing/sanitizing technique prior to providing peri/catheter care.  2) All residents have the potential to be affected by the deficient practice.  3) Staff were inserviced on 12/18/13 regarding proper technique of washing/sanitizing of their hands after gathering supplies prior to providing peri care.  4) Staff development nurse will observe nursing assistants for proper technique of handwashing/sanitizing after gathering supplies prior to proving peri/catheter care. The staff development nurse will observe a minimum of three nursing assistants a week for thirty days, then every other week for thirty days. The need for further follow up will be determined by the findings during the peri/catheter care observations.  5) Completion date: 12/30/13</p>	12/30/13
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F 441	<p>Continued From page 7</p> <p>hands and change gloves after gathering equipment for perineal care and providing the care to Resident #9.</p> <p>The findings include:</p> <p>Review of the facility policy titled, "Hand Washing Policy, dated May 2012, revealed the facility considers hand hygiene the primary means to prevent the spread of infections. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors".</p> <p>1. Observation on 12/03/13 at 11:37 AM revealed, a student State Registered Nurse Aide and a Nurse Aide were not washing or sanitizing their hands between tray passes after coming in contact with residents. Additional observation revealed the Nurse Aide was delivering dirty dishes to the dirty tray return window and then would deliver a clean tray without washing/sanitizing his hands.</p> <p>Interview with the Director of Nursing (DON) and Administrator, on 12/05/13 at 10:08 AM, revealed staff are required to sanitize hands during meals if they touch a resident or touch an unclean area such as the floor. If a staff makes contact with a dirty area such as the residents food tray/plate, they should sanitize their hands before delivering the next tray.</p> <p>2. Record review revealed the facility admitted Resident #9 on 01/05/12 with diagnoses which included Alzheimers, Allergic Rhinitis, Anxiety and Urinary Retention. Review of the quarterly</p>	F 441			

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F 441	<p>Continued From page 8</p> <p>Minimum Data Set (MDS) assessment, dated 08/27/13 revealed the facility assessed Resident #9's cognition as severely impaired.</p> <p>Observation, on 12/05/13 at 8:55 AM with Certified Nursing Assistant (CNA) #4, revealed he did not wash his hands or change gloves after gathering the perineal care supplies and prior to providing perineal care and catheter care to the resident.</p> <p>Interview, on 12/05/13 at 9:05 AM with CNA #4, revealed he should have gathered his supplies before washing his hands and gloving. CNA #4 stated he should wash hands and glove and not touch any foreign objects before providing resident care.</p> <p>Interview, on 12/05/13 at 9:07 AM with Registered Nurse (RN) #1, revealed staff should gather supplies (water, rags) prior to washing hands and applying gloves. The RN stated the CNA needed education on cross contamination.</p> <p>Interview, on 12/05/13 at 9:10 AM with RN #3, Infection Control Nurse, revealed if staff touch dirty, staff needs to wash their hands and change gloves. RN #3 stated the CNAs should gather everything needed before they wash their hands and apply their gloves to provide care to a resident.</p> <p>Interview, on 12/05/13 at 10:20 AM with Director of Nursing (DON), revealed staff should gather their supplies before they wash their hands and apply gloves to provide care to residents.</p>	F 441			

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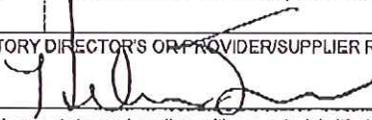
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01.</p> <p>PLAN APPROVAL: 1972.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (211).</p> <p>SMOKE COMPARTMENTS: Three (3) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1972, with 20 smoke detectors and 0 heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system installed in 1972.</p> <p>GENERATOR: Type II generator installed in 1972. Fuel source is Liquid Propane.</p> <p>A standard Life Safety Code survey was conducted on 12/03/13. Superior Care Home was found in non-compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for Eighty-Eight (88) beds with a census of Seventy-One (71) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from</p>	K 000	<p>Preparation and execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. This Plan of Correction is prepared and executed solely because it is required by federal and state laws. The facility reserves the right to revise/improve corrective actions as determined to be warranted.</p> <p><u>K025</u></p> <ol style="list-style-type: none"> <li>1) A contractor was contacted to make the necessary access point in the ceiling.</li> <li>2) All residents have the potential to be affected by the deficient practice.</li> <li>3) Another access point will be created to allow viewing of the smoke barrier located at room 202.</li> <li>4) Once the new access point is created the concern will be resolved permanently.</li> <li>5) Completion date: 1/3/14</li> </ol>	1/3/14
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE



Administrator 2-4-14

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185227	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  12/03/2013
NAME OF PROVIDER OR SUPPLIER  SUPERIOR CARE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 CLAY STREET PADUCAH, KY 42001	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Fire).	K 000		
K 025 SS=E	Deficiencies were cited with the highest deficiency identified at "E" level. NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4  This STANDARD is not met as evidenced by: Based on observations and interview, it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments in accordance with NFPA standards. The deficiency had the potential to affect two (2) of three (3) smoke compartments, forty-six (46) residents, staff and visitors. The facility is certified for Eighty-Eight (88) beds with a census of Seventy-One (71) on the day of the survey. The facility failed to ensure one (1) smoke barrier was accessible to verify the wall was sealed.  The findings include:  Observations, on 12/03/13 at 11:50 AM with the	K 025		

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K 025	<p>Continued From page 2</p> <p>Maintenance Supervisor and the Administrator, revealed the smoke partition, extending above the ceiling, located at room #202 was inaccessible after multiple attempts to find a way to view the smoke barrier.</p> <p>Interview, on 12/03/13 at 11:50 AM with the Maintenance Supervisor and the Administrator, revealed they were unaware the facility had to have access to the smoke barrier in order to check the integrity of the wall.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows:</p> <p>(a) The space between the penetrating item and the smoke barrier shall</p> <ol style="list-style-type: none"> <li>1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or</li> <li>2. Be protected by an approved device designed for the specific purpose.</li> </ol> <p>(b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall</p> <ol style="list-style-type: none"> <li>1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or</li> <li>2. Be protected by an approved device designed for the specific purpose.</li> </ol> <p>(c) Where designs take transmission of vibration into consideration, any vibration isolation shall</p> <ol style="list-style-type: none"> <li>1. Be made on either side of the smoke barrier, or</li> <li>2. Be made by an approved device designed for the specific purpose.</li> </ol>	K 025		

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K 025	Continued From page 3  8.3.6.2 Openings occurring at points where floors or smoke barriers meet the outside walls, other smoke barriers, or fire barriers of a building shall meet one of the following conditions: (1) It shall be filled with a material that is capable of maintaining the smoke resistance of the floor or smoke barrier. (2) It shall be protected by an approved device that is designed for the specific purpose.	K 025	<u>K072</u>  1) The tables and 32 gallon linen barrel and carts were removed on 12/3/13.  2) All residents have the potential to be affected by this deficient practice.  3) Staff have been instructed by the administrator not to place items in the hallway i.e. linen barrels, carts or tables.  4) To maintain an unimpeded hallway, the maintenance supervisor will observe the back exit corridor weekly to be certain that it remains unimpeded. This observation will be performed for thirty days. Further follow up or education will be determined through the QA process by the findings during the observation period.  5) Completion date: 12/30/13	
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain exit access in accordance with NFPA standards. The deficiency had the potential to affect one (1) of three (3) smoke compartments, twenty (20) residents, staff and visitors. The facility is certified for Eighty-Eight (88) beds with a census of Seventy-One (71) on the day of the survey. The facility failed to ensure tables, carts, and trash can were properly stored out of the corridor when not in use.	K 072		

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K 072	Continued From page 4  The findings include:  Observation, on 12/03/12 between 11:00 AM and 4:00 PM with the Maintenance Supervisor, revealed two (2) tables, a 32 gallon trash can, and 2 carts stored for over three (3) hours in the back exit corridor.  Interview, on 12/03/12 between 11:00 AM and 4:00 PM with the Maintenance Supervisor, revealed the facility routinely stored the tables in the corridor and the trash can pushed to one side of the corridor.  Reference: NFPA 101 (2000 Edition) Means of Egress Reliability 7.1.10.1 Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.	K 072	<u>K130</u> 1) Lint was cleaned from the dryer vents. Door stops were removed from the kitchen door, med rooms, housekeeping closets and the magnet was removed from the laundry door.  2) All residents have the potential to be affected by the deficient practice.  3) Maintenance supervisor has been instructed not to place door stops on the med room doors, housekeeping closets or the kitchen door. He has further been instructed not to place a magnet on the laundry room door. Dryer vents are now scheduled for cleaning on a weekly basis. The dryer vents will be monitored for cleanliness by the Asst. Administrator weekly for 30 days. Door stop/magnet placement will be monitored by the Asst. Administrator weekly for 30 days. Dryer vent cleanliness and door stop/magnet placement will be monitored thru the QA process for continuation of compliance.  4) Maintenance supervisor has been instructed not to place door stops on the med room doors, housekeeping closets or the kitchen door. He has further been instructed not to place a magnet on the laundry room door.	
K 130 SS=D	NFPA 101 MISCELLANEOUS  OTHER LSC DEFICIENCY NOT ON 2786  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the hazardous areas in accordance with NFPA standards. The deficiency had the potential to affect two (2) of three (3) smoke compartments, Seventy-One (71) residents, staff and visitors. The facility is certified for Eighty-Eight (88) beds with a census of	K 130	5 Completion date: 12/30/13	12/30/13

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K 130	<p>Continued From page 5</p> <p>Seventy-One (71) on the day of the survey. The facility failed to ensure the area behind the dryers was properly maintained to be free of lint buildup and doors were not equipped with doorstops.</p> <p>The findings include:</p> <p>Observation, on 12/03/13 at 2:10 PM with the Maintenance Supervisor, revealed a heavy build-up of lint in the top of the dryer.</p> <p>Interview, on 12/03/13 at 2:10 PM with the Maintenance Supervisor, revealed he was not aware the lint build up was so excessive.</p> <p>Observation, on 12/03/13 between 1:10 PM and 4:00 PM with the Maintenance Supervisor, revealed a door stop attached to the med rooms on 100 &amp; 200 hall, the housekeeping closets on 100 &amp; 200 hall, kitchen door, and a magnet attached to the laundry door.</p> <p>Interview, on 12/03/13 at 2:10 PM with the Maintenance Supervisor, revealed the door stops were there to help get carts and stock in and out of the rooms.</p> <p>NFPA 101 (2000 Edition) 4.6.12 Maintenance and Testing. 4.6.12.1 Whenever or wherever any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provisions of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be continuously maintained in accordance with applicable NFPA requirements or as directed by the authority having jurisdiction. NFPA 101 (2000 Edition) 7.2.1.8 Self-Closing Devices. 7.2.1.8.1* A door normally required to be kept</p>	K 130		
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K 130	Continued From page 6 closed shall not be secured in the open position at any time and shall be self-closing or automatic-closing in accordance with 7.2.1.8.2.	K 130			